VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: JOHN HENRY HAGMANN, M.D.
License No.: 0101-226760

ORDER

In accordance with the provisions of Sections 54.1-105, 54.1-110, 2.2-4020, and 2.2-4021 of the Code of Virginia (1950), as amended ("Code"), a formal administrative hearing was convened before the Virginia Board of Medicine ("Board"), on June 19, 2015, in Henrico, Virginia, to receive and act upon evidence that John Henry Hagmann, M.D., may have violated certain laws and regulations governing the practice of medicine and surgery in the Commonwealth of Virginia. These matters are set forth in the Board's Notice of Hearing and Statement of Particulars dated March 12, 2015.

Pursuant to Section 54.1-2400(11) of the Code, the hearing was held before a panel of the Board with a member of the Board presiding. Assistant Attorney General Erin Barrett, was present as legal counsel for the Board. The proceedings were recorded by a certified court reporter. The case was prosecuted by Frank W. Pedrotty, Senior Assistant Attorney General and Melanie Pagano, Adjudication Specialist. Dr. Hagmann did not appear at the formal administrative hearing and was not represented by counsel.

FINDINGS OF FACT

Now, having properly considered the evidence and testimony presented, the Board makes the following findings by clear and convincing evidence:

1. John Henry Hagmann was issued license number 0101-226760 by the Virginia Board of Medicine ("Board") to practice medicine and surgery in the Commonwealth of Virginia on May

24, 2000. Said license was summarily suspended by the Board on March 12, 2015.

2. Based upon the representations of Frank W. Pedrotty, Senior Assistant Attorney General, and Commonwealth's Exhibits 1 and 12, the Notice of Formal Hearing and Affidavit of Mailing, the presiding officer ruled that adequate notice was provided to Dr. Hagmann, and the hearing proceeded in his absence.

3. Dr. Hagmann exploited participants in his military course training programs for his personal gain. Additionally, Dr. Hagmann's conduct during his military course training programs represents a danger to the health and welfare of his patients and the public. Specifically, by Dr. Hagmann's own admission, while conducting training courses for his business, Deployment Medicine International ("DMI"), in or about 2012 and 2013 in Colorado, Virginia, the United Kingdom, Maryland, and North Carolina, he authorized and allowed course participants, including medical students/military officers who he recruited from a uniformed services university in Maryland, to perform invasive medical procedures on each other. These procedures were not undertaken or provided in good faith for medicinal or therapeutic purposes, were undocumented, and were not performed under adequate or appropriate sterile conditions. Examples of such procedures performed in these courses in or about July 2012 and 2013 include the following:

a. During an Operational Medicine and Emergency Skills ("OEMS")/Procedures in Casualty Care ("PCC") course conducted at Dr. Hagmann's training facility in Partlow, Virginia, his 32-acre farm, from approximately July 5-8, 2013, Dr. Hagmann instructed, authorized or allowed course participants, who were not licensed by the Virginia Department of Health Professions, to perform invasive procedures on one another, as follows:

i. A course participant initiated a Foley catheterization on Patient A, discussed in

more detail below in Paragraph 8(a). When the course participant was unable to successfully catheterize the patient, Dr. Hagmann took over the procedure, changing the catheterization tubing.

ii. A course participant performed a Foley catheterization on Patient B.

iii. The Board heard testimony from Colonel Neil Page, an investigating officer assigned to investigate the initial claims made regarding Dr. Hagmann's classes. Colonel Page, who is a military physician with significant combat medical experience, testified that there is no medical reason to insert a Foley catheter when trauma on the battlefield is being treated by emergency personnel.

b. During an OEMS/PCC course conducted in the United Kingdom in or about July 2012, attended by United States citizens who were medical students and/or members of the military, course participants performed the following invasive procedures on one another, as follows:

i. Patient D performed a Foley catheterization on Patient E.

ii. Subsequently, Dr. Hagmann informed Patient D that he would receive ketamine (C-III), followed by "a procedure." Individual 1, a uniformed services university student acting as the DMI OEMS course coordinator who was present, stated that, subsequent to the administration of ketamine and midazolam (C-IV), Patient D was catheterized by Patient E, followed by an intravenous ("IV") insertion by course participants. Individual 1 stated that Patient D was not told, prior to receiving ketamine and midazolam, what procedure would be performed, so that the effects of medication(s) on his post-procedure recollection could subsequently be assessed.

c. During an OEMS/PCC course held at a uniformed services medical university in Maryland in or about 2012, Dr. Hagmann conducted one or more "shock labs," which involved withdrawing blood from medical students in order to observe signs of hypovolemia (i.e. shock). These procedures induced multiple syncopal episodes in students for which no hemodynamic monitoring or efforts at resuscitative measures were taken. No efforts were made to provide emergency services to affected students.

d. During an OEMS/PCC course held approximately July 13-20, 2013 at Dr. Hagmann's training facility in Pink Hill, North Carolina, his 20-acre property, course participants performed invasive procedures on one another, as follows:

i. After watching a video on Foley catherization, course participants were encouraged to "practice" on one another. When the course participants appeared hesitant, Dr. Hagmann volunteered to be the first "subject," and made demeaning remarks to the men in the group for not volunteering. Subsequently, one female was catheterized and the four males in the group were catheterized, some of them twice.

ii. Individual 2, the first course participant chosen by Dr. Hagmann to catheterize a male patient, testified to the Board that she performed the procedure without adequate instruction. Individual 2 further testified that she thought Dr. Hagmann intentionally withheld the necessary instruction because she had previously been critical of the live tissue training portion of the course, and he was "trying to embarrass [her]" in retaliation for the criticism.

e. During an OEMS/PCC and/or Mission Performance at High Altitude ("MPHA") course held in or about July 2013 in Leadville, Colorado, conducted at a high altitude location

in rented huts, Patient C was administered a FAST I sternal intraosseous infusion. The metal catheter tip was left embedded in Patient C's sternum, requiring open surgical removal. After making an incision down to the periosteum, Dr. Hagmann removed the device with needle drivers without using sterile techniques. According to Patient C, Dr. Hagmann allowed course participants who had never sutured a live person to use the opportunity to get some practice by suturing Patient C's wound. Subsequently, when several of the course participants began poorly suturing Patient C's wound due to lack of experience, Dr. Hagmann left the area in disgust, claiming that he could not bear to watch.

4. In the absence of proper training and supervision, and absent medicinal or therapeutic purposes within the course of his professional practice, Dr. Hagmann dispensed controlled substances to and instructed, authorized, or allowed course participants, who were not licensed by the Virginia Department of Health Professions, to administer to or inject each other or themselves with ketamine; midazolam; lorazepam (C-IV); lidocaine (C-VI); benzocaine (C-VI); heparin (C-VI); Diamox (C-VI); prednisone (C-VI); dexamethasone (C-VI); and Viagra (C-VI). Further, Dr. Hagmann directed, authorized, or allowed course participants to engage in "ketamine labs," "alcohol labs" or "studies," and "cognition labs," which involved the dosing of ketamine (a disassociative anesthetic) and consumption of alcohol, at times in combination or in quick succession, so that he could allegedly assess the effects of these substances on their cognition. None of these labs or studies was approved by an Institutional Review Board ("IRB"). Specifically:

a. In or about 2012, during the OEMS course(s) conducted at the uniformed services university in Maryland, students participated in a "ketamine lab," wherein they were injected with ketamine in order to observe its effects.

b. In or about July 2012 during the OEMS/PCC course in the United Kingdom:

i. Several course participants received morphine (C-II) or ketamine injections, administered by Dr. Hagmann or one of the course participants.

ii. After receiving ketamine, midazolam, and IV fluid, Patient D was catheterized, as detailed above in Paragraph 3(b)(ii).

c. In or about July 2013, at the OEMS/PCC course in Partlow, Virginia, as part of a "cognition lab," course participants were asked to complete cognition tests prior to and after consuming approximately eight (8) ounces of bourbon in a span of approximately 20-30 minutes. According to Patient C, this lab was "part of training." Patient C further stated that participants were permitted or encouraged to "chase" the bourbon with beer. Patient C testified that the atmosphere surrounding the "lab" was that of a drinking party and seemed irregular.

d. In or about July 2013, at the OEMS/PCC course in Pink Hill, North Carolina:

i. As part of a "cognition lab," course participants were asked to complete cognition tests prior to and after consuming approximately eight (8) ounces of 80-proof rum within approximately ten minutes. Two participants each drank an additional approximate four (4) ounces of rum.

ii. Approximately one hour or less after consuming rum as part of the "cognition lab," several course participants were injected with ketamine to allow them to feel the effects. Regarding four participants who consumed alcohol (rum) and received ketamine injections:

- Patient F experienced a negative reaction to the ketamine and began crying. Lorazepam was administered in an effort to calm her down. Despite the fact that Dr. Hagmann was the only licensed health care provider present and despite administering a combination of substances that would normally be considered immediately life-threatening (i.e. a benzodiazepine and alcohol, both of which are respiratory depressants that in combination can be lethal), he did not monitor Patient F's condition or offer follow-up care. Instead, Individual 2 cared for Patient F by placing her in the recovery position.
- Patient U became nauseated almost immediately after receiving ketamine (having consumed approximately twelve (12) ounces of rum within the previous hour) and began vomiting. Dr. Hagmann and another course participant, who was inebriated, discussed performing a penile nerve block on Patient U. Individual 2 twice informed Dr. Hagmann and the other course participant that she did not think it was appropriate for him to perform a penile nerve block on Patient U, who was incapable of giving informed consent. Subsequently, two other course participants approached Individual 2 and stated that they had not agreed with the proposed procedure, and Patient U later stated that he was glad that Individual 2 had interceded on his behalf.
- Patient H, who received ketamine after consuming rum, underwent a penile nerve block while intoxicated.
- Patient W received three (3) doses of ketamine. Despite the fact that Dr. Hagmann was the only licensed health care provider present, he did not monitor

this patient's condition or offer follow-up care. Patient W asked Individual 2 to stay up with him before retiring at approximately 3:45 a.m. Individual 2 testified that Patient W hallucinated in response to the doses of ketamine.

iii. Subsequent to the incident with Patient U, on that same evening, Dr. Hagmann volunteered himself for a penile nerve block, which impaired course participants performed on him.

e. In or about July 2013, at the Mission Performance at High Altitude ("MPHA") course in Leadville, Colorado, conducted at a high altitude location in rented huts:

i. As part of a "cognition lab" conducted on or about the evening of July 11, 2013, in which cognition was being studied at various altitudes, participants, who were described by Patient C as "pressured" into participation, performed the same or similar cognition tests prior to and after consuming quantities of bourbon, similar to the participants in the Virginia and North Carolina "alcohol labs."

ii. Patient C stated that, as part of a "ketamine lab" conducted late in the evening on or about July 12, 2013, Patient J, a Dutch military commando attending the course, was administered a micro-dose of ketamine in order to purportedly "demonstrate the intoxicating effects of the drug."

iii. In or about the late evening of July 12, 2013, ketamine and midazolam were administered to Patient K to demonstrate, according to Patient C, the "calming effects of adding midazolam to micro-dose ketamine, and also to show the suggestibility of a patient dosed with this combination of drugs" (also witnessed by Individual 4). Prior to receiving the ketamine and midazolam, Patient K had expressed reservations about

undergoing a tibial intraosseous infusion, which was known to be painful. After receiving the medications, however, he was "easily manipulated into accepting the procedure," according to Patient C. Although the procedure was not performed, the administration for the purpose of the infusion was.

iv. Patient C testified that Dr. Hagmann had the course participants perform a shock lab on one student while at the remote location in Colorado. Patient C testified that, during this shock lab, where blood was removed from a student at altitude, the nearest trauma medical center, should it be needed due to this procedure, was likely several hours away. Furthermore, there was no physiologic monitoring that would meet even the basic standard of care during this procedure.

f. In or about July 2013 at the MPHA course in Partlow, Virginia and/or Leadville, Colorado, Dr. Hagmann dispensed or administered Diamox, prednisone, and dexamethasone for "working at altitude" testing and Viagra for "aerobic performance at altitude" testing to Patients J – T as follows:

- Patients J and K - Diamox and Viagra
- Patients L, O, P and S - Diamox
- Patients M and N - prednisone or dexamethasone and Diamox
- Patients Q and R - prednisone or dexamethasone, Diamox, and Viagra
- Patient T - prednisone and Diamox

The Board noted that the combination of Diamox, Viagra and acute altitude changes is a dangerous combination that could result in acute hypotension, injury and death.

g. In or about July 2013, as shown in a DMI training video provided by Dr. Hagmann to

the Department of Health Professions' investigator in or about July 2014, Dr. Hagmann authorized or allowed Individual 5 to perform a femoral arterial blood gas ("ABG") on Patient I.

h. Dr. Hagmann's July 2013 medication and dispensing logs for ketamine, lorazepam, and midazolam indicate that he transferred these medications from Gig Harbor, Washington to Partlow, Virginia and dispensed or administered these medications to Patients F, K, R, U, V, and W, or dispensed and instructed course participants, who were not licensed health care practitioners, to administer these medications to themselves or each other, as follows:

Date	Patient	Medication/dosage administered
7/7/13	Patient F	0.5 mg/.25 ml lorazepam
7/8/13	Patient U	3mg/0.6 ml midazolam
7/10/13	Patient K	100 mg/1ml ketamine; 2mg/0.4 ml midazolam
7/10/13	Patient R	200 mg/2 ml ketamine
7/18/13	Patient F	25 mg/0.25 ml ketamine
7/18/13	Patient U	100 mg/1 ml ketamine
7/18/13	Patient V	100 mg/1 ml ketamine
7/18/13	Patient W	125 mg/1.25 ml ketamine

5. Dr. Hagmann dispensed, as detailed in Paragraph 4, C-III and C-IV controlled substances (ketamine, midazolam, and lorazepam) to patients/individuals without being licensed by the Board of Pharmacy, as required by Section 54.1-3302 of the Code.

6. Dr. Hagmann failed to maintain a dispensing log for morphine administered to DMI course participants, despite the fact that his drug invoices indicate that he purchased 50 units of injectable morphine sulfate on or about July 1, 2013 and an additional 50 units on or about November 7, 2013. Further, Dr. Hagmann admitted to the DHP investigator that he used morphine in a course offered to participants from the Department of Energy and Individual 3 stated that at least one

student was administered morphine during the July 2012 OEMS/PCC course in the United Kingdom (as detailed in Paragraph 4(b)(i)). Additionally, Dr. Hagmann failed to maintain a dispensing log for the "high altitude" medications he dispensed to patients in Virginia and/or Colorado in or about July 2013, as detailed in Paragraph 4(f).

7. Dr. Hagmann failed to obtain adequate or appropriate consent from Patients F, U, H, and W, who were purported to have "consented" to the administration of ketamine and benzodiazepines while under the influence of alcohol, as detailed in Paragraph 4(d). Colonel Page testified to the Board that no proper consent was obtained for any of the procedures performed during Dr. Hagmann's courses. Colonel Page testified that, in an environment that was already coercive due to the natural relationship between a medical instructor and his students, the students could not provide voluntary, informed consent to the procedures to which they were subjected.

8. From approximately July 5-8, 2013, Dr. Hagmann exploited, for personal gain and sexual gratification, Patients A and B, participants in his Partlow, Virginia DMI OEMS/PCC course, as follows:

a. After a course participant had difficulty passing a catheter through Patient A, Dr. Hagmann changed the tubing type or size and catheterized the patient. Later that day, Dr. Hagmann approached the patient and recommended a "private" prostate exam to determine a physical reason for the difficulty. At approximately 10:30 p.m. that evening, with no chaperone and in an isolated area, Dr. Hagmann conducted a detailed physical examination of Patient A's penis, testicles, and rectum. Patient A testified that he had consumed alcohol that evening, which may have led him to overlook any concerns related to Dr. Hagmann's exam proposal. Patient A later stated to Colonel Page, the investigating officer assigned to review

the circumstances surrounding student complaints against Dr. Hagmann, that the rectal exam "took longer than expected and made me feel uncomfortable." According to Patient A's testimony, Dr. Hagmann stated "I know I violated you there" and offered to allow Patient A to perform a digital rectal exam on Dr. Hagmann, which Patient A declined. Patient A later related this series of events to Patient C, who testified to the same before the Board. Patient A testified that he felt violated by Dr. Hagmann. Patient A stated that there was no medical reason to have a medical student "experience" a Foley catheter and that there was no medical reason for Dr. Hagmann to perform a digital rectal exam on Patient A. Patient A testified that he served in the Infantry for several years prior to attending medical school and had never experienced the treatment that he and his colleagues received in Dr. Hagmann's classes.

b. Patient B was catheterized by another course participant, during which Dr. Hagmann noticed that the patient was uncircumcised. Subsequently, on or about the evening of July 8, 2013, after all other course participants had left the Partlow, Virginia premises, and while consuming beer with Patient B, Dr. Hagmann "boast[ed]"about his proficiency with rectal exams. Dr. Hagmann then drove with Patient B to a warehouse on the property to practice "additional procedures." At the warehouse, Patient B, at Dr. Hagmann's request, performed a "femoral blood gas" on him, after which he requested that Patient B perform a focused pelvic trauma examination on Dr. Hagmann , including a penile and rectal examination, stating that he would talk Patient B through it. This examination was videotaped, according to Dr. Hagmann, for future training purposes; however, Patient B stated that the video has not been requested for course material. Further, while they both continued to consume beer, Dr. Hagmann questioned Patient B about the effect his uncircumcised penis had on masturbation

and sexual intercourse and asked to photograph the patient's penis with Dr. Hagmann's personal camera during various stages of manipulation of the foreskin, purportedly to use as a "training tool." Patient B, who stated that he was inebriated and felt that he could not refuse Dr. Hagmann's request, acquiesced and allowed him to examine, manipulate, and photograph his penis. Patient B testified that these procedures lasted about an hour. Patient B also testified that he had no way to leave the facility, as Dr. Hagmann was driving Patient B to the airport the following day and the two were alone. Patient B testified that he had no cell phone reception, was unfamiliar with the location, was dependent on Dr. Hagmann for transportation to and from the facility, and felt very isolated and alone. Patient B testified that he felt violated by Dr. Hagmann.

c. Individual 2 testified before the Board that Dr. Hagmann's actions appeared to be "grooming behavior." Specifically, Individual 2 testified that Dr. Hagmann appeared to target first-year medical students without significant medical experience, and furthermore that the initial procedures course participants were asked to perform involved extremities such as fingers, later moving toward a focus on the pelvic region for catheters and rectal exams.

9. On or about July 8, 2013, while he was under the under the influence of alcohol, Dr. Hagmann examined/treated Patient B as detailed in Paragraph 8(b), and on or about July 9, 2013, he demonstrated a penile nerve block on a patient while under the influence of alcohol.

10. Regarding Dr. Hagmann's care and treatment of Patients A - H and J - W, in or about 2012 and 2013:

a. Prior to performing or instructing, authorizing, or allowing others to perform invasive procedures on or administer controlled substances to these patients, Dr. Hagmann failed to

obtain and/or record medical histories. Further, despite the fact that Dr. Hagmann was the only licensed health care provider at the DMI courses he offered, during some procedures Dr. Hagmann was not present, such as when Patient C was being sutured by course participants, as detailed in Paragraph 3(e).

b. Dr. Hagmann failed to monitor and/or record the monitoring of the patients' vital signs during the invasive procedures performed on them, and failed to maintain medical records for certain procedures, as follows:

i. During an OEMS/PCC course conducted at Dr. Hagmann's training facility in Partlow, Virginia, from approximately July 5-8, 2013:

- Patient A's Foley catheterization, as detailed in Paragraph 3(a)(i).
- Patient B's Foley catheterization, as detailed in Paragraph 3(a)(iii).
- Patient C's FAST I sternal intraosseous infusion, as detailed in Paragraph 3(e).

ii. During an OEMS/PCC course conducted in the United Kingdom in or about July 2012:

- Patient D's Foley catheterization and IV treatment, as detailed in Paragraphs 3(b)(ii) and 4(b)(ii).
- Patient E's Foley catheterization, as detailed in Paragraph 3(b)(i).

iii. During an OEMS/PCC course conducted in Pink Hill, North Carolina in or about July 2013:

- Patient H's penile nerve block, as detailed in Paragraph 4(d).

c. Regarding Patients F, U, H, and W, Dr. Hagmann failed to provide follow-up care subsequent to their intoxication or adverse reactions caused by the administration of

ketamine after consuming alcohol, as detailed in Paragraph 4.

d. Regarding Patients J, K, L, M, N, O, P, Q, R, S, and T, Dr. Hagmann failed to record patient information regarding the administration, in or about July 2013, of "altitude" medications to these patients, to include Diamox, Viagra, prednisone, and/or dexamethazone, including the medical indication for administration and the effects that these medications had on these patients, detailed above in Paragraph 4(f).

e. Regarding Patients F, K, R, U, V, and W, listed in Dr. Hagmann's July 2013 dispensing logs for ketamine, lorazepam, and midazolam, he failed to record patient information regarding the administration of these medications to these patients, including the medical indication for administration and the effect that these medications had on these patients.

10. Regarding Patient X, a 45-year-old male (as of March 17, 2005), who Dr. Hagmann treated, by his own admission, for pain management from approximately March 17, 2005 – February 19, 2014 at his Partlow, Virginia course facility, at his Gig Harbor, Washington residence, and/or telephonically:

a. Despite the fact that Dr. Hagmann's initial March 17, 2005 medical record for Patient X, a Virginia resident, indicates that the patient requested on this date "refills of chronic medications for frequent episodes of paraspinous muscle spasm," as well as of Viagra, and that, on or about that date, he prescribed the patient Percocet (C-II), Viagra, baclofen (C-VI), and chlordiazepoxide (C-VI), Dr. Hagmann's medical record fails to note any related examinations, consultation findings, or adequate rationale to support such prescribing.

b. Beginning with Patient X's initial visit on or about March 17, 2005 and continuing

through in or about February 2014, Dr. Hagmann failed to record the patient's blood pressure, weight, and other standard vitals, and failed to consistently perform and/or document adequate physical assessments and examinations of Patient X. Over the course of approximately nine (9) years, there are references in his treatment records to physical examinations on only three occasions: January 21 and June 21, 2008, wherein on both occasions Dr. Hagmann noted "Full PE WNL"and "Mild L lumbar paraspinous spasm not symptomatic but visible and palpable"; and May 12, 2012, wherein Dr. Hagmann noted: "Complete PE performed. NL. No neuro deficit, but spasm. "

c. Despite the fact that Dr. Hagmann referred in his medical record to Patient X's back surgeries (April 2009 and September 2013) and physical therapy (January/February 2014) and noted this treatment in his statement to the Virginia Department of Health Professions' investigator, he failed to consult or coordinate the patient's care and treatment with other treatment providers.

d. Despite the fact that Dr. Hagmann treated Patient X for pain management for approximately nine years, prescribing him Percocet, chlordiazepoxide, tramadol (C-VI), and/or Mobic (C-VI), he failed to develop a comprehensive treatment plan and/or to adequately review and monitor the efficacy of Patient X's treatment, including monitoring and managing Patient X's usage of narcotic and benzodiazepine medications. Specifically:

i. Dr. Hagmann failed to employ pain rating scales or other appropriate measures to determine the effect of prescribed medications on Patient X's activities of daily living.

ii. Dr. Hagmann did not have a pain management or similar contracts in place with Patient X, for whom he regularly prescribed narcotic and benzodiazepine medications.

iii. Dr. Hagmann failed to order any drug urine/serum screens, conduct pill counts, or take other appropriate measures to determine whether Patient X was taking his medications as prescribed and was otherwise compliant with his medication regimen. Further, despite the fact that Dr. Hagmann purported to "have assumed the role of medication 'gatekeeper'" for Patient X, as he stated to the DHP investigator, he failed to consult or coordinate the patient's prescribed pain medication with other providers and/or record prescriptions from other providers in his medical record. This failure resulted in the patient obtaining approximately 330 dosage units of Percocet, 15 dosage units of hydromorphone (C-II), and 90 dosage units of hydrocodone-acetaminophen (Vicodin, C-III) from approximately November 23, 2013 – January 23, 2014.

12. Investigating officer Colonel Neil Page testified that the boundary between a medical instructor and a medical student is necessary for proper medical instruction. Colonel Page testified that Dr. Hagmann crossed the boundary by insisting that students perform procedures on Dr. Hagmann and by Dr. Hagmann, in turn, performing procedures on his students. Colonel Page testified that a practitioner-patient relationship existed between Dr. Hagmann and course participants undergoing procedures even when the procedures were performed by other students under Dr. Hagmann's direction.

13. Colonel Page testified that the use of ketamine in an instructional setting would never be warranted because the risks far outweigh any potential benefits. During his investigation of Dr. Hagmann's courses, Colonel Page discussed the use of ketamine in an instructional setting with anesthesiologists, who were horrified by such practice.

14. Colonel Page testified that there is no medically justified reason to combine the

use of alcohol and ketamine. Additionally, use of alcohol in the military theater is never appropriate and never condoned under military practice.

15. The Board heard testimony from Dr. John Prescott, chief academic officer of the Association of American Medical Colleges. Dr. Prescott testified to the Board that it is unheard of to have students perform Foley catheters on each other during medical training. Dr. Prescott testified that the simulation lab at the students' medical school is one of the best in the country. Dr. Prescott testified that the procedures the students performed on one another and Dr. Hagmann were procedures that the medical students need to learn, but that students learn those procedures in their normal medical training. Dr. Prescott stated that performing procedures in this way, including by ingesting alcohol and injecting medications, made no sense in a medical educational setting. During his testimony, Dr. Prescott appeared shocked by the facts in this case.

16. Individual 2 testified that, during her participation in the Pink Hill, North Carolina course, she was given a sternal intraosseous infusion on the living room floor of the facility after she had ingested alcohol. Individual 2 testified that the procedure resulted in a keloid formation that required surgical revision. Individual 2 testified that she experiences continued pain and will likely require additional surgical intervention.

17. Individual 2 testified that, during her participation in the course in Pink Hill, North Carolina, she underwent a digital nerve block, a radial nerve block, a posterior tibial nerve block, a femoral nerve block and an axillary nerve block. The Board notes that such blocks can be life-threatening if not monitored and can potentially cause structural damage.

18. Individual 3 testified that, during her participation in the course in the United

Kingdom, she was given a tibial intraosseous infusion and the procedure was extremely painful. Individual 3 testified that the handle of the intraosseous device broke off prior to removal. Dr. Hagmann and the other course participants used pliers to remove the handle and metal tip of the catheter. Individual 3 testified that she was given one dose of ciprofloxacin by Dr. Hagmann following this procedure.

19. Individual 3 further testified that, in a later course at the university, she participated in a "hydration lab." Some students ingested a certain amount of water every hour, another group ingested a performance beverage, and another group was administered intravenous ("IV") fluid. Individual 3 was assigned to the water ingestion group and had to stop her participation after getting sick. Individual 3 testified that she did not know what the value or point of the hydration lab was.

20. Patient B testified to the Board that he and other students performed procedures on each other while drinking alcohol. During Patient B's training, Dr. Hagmann provided the alcohol consumed by the students.

21. Participants in Dr. Hagmann's courses that testified before the Board did not see resuscitation equipment readily-available during any of these procedures.

22. The Board notes that ketamine, an agent with no known antidote, was being routinely and cavalierly used by Dr. Hagmann in his courses with no patient monitoring.

23. As confirmed by multiple witnesses, Dr. Hagmann's actions were predatory and coercive. The Board finds that Dr. Hagmann exploited the power differential between patients and practitioners, military rank (regardless of Dr. Hagmann's retired status) and medical teachers and their students.

24. Dr. Hagmann violated the trust of his students on all levels in one of the most egregious misuses of the multiple relationships between physicians, patients and students.

25. The Board recognizes the courage of the students and their university in addressing these shocking issues.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes that:

1. Finding of Fact No. 3 constitutes a violation of Sections 54.1-2915.A(3), (11), (12), (13), (16) and (18) and 54.1-3303.A of the Code of Virginia (1950), as amended ("Code") and 18 VAC 85-20-29.A(1) and (3) of the Board of Medicine General Regulations ("Regulations").

2. Finding of Fact No. 4 constitutes a violation of Sections 54.1-2915.A(3), (8), (11), (12), (13), (16), (17) and (18); 54.1-3303.A; and 54.1-3408.A-B of the Code, and 18 VAC 85-20-29.A(1) of the Regulations.

3. Finding of Fact No. 5 constitutes a violation of Sections 54.1-2915.A(17) and (18) and 54.1-3304 of the Code.

4. Finding of Fact No. 6 constitutes a violation of Sections 54.1-2915.A(17) and (18) and 54.1-3404.D of the Code.

5. Finding of Fact No. 7 constitutes a violation of Section 54.1-2915.A(3), (13) and (16) of the Code.

6. Finding of Fact No. 8 constitutes a violation of Section 54.1-2915.A(3), (12), (13), (16), (18) and (19) of the Code and 18 VAC 85-20-29(3) and 18 VAC 85-20-100 of the Regulations.

7. Finding of Fact No. 9 constitutes a violation of Section 54.1-2915.A(3), (13) and (16) of the Code.

8. Finding of Fact No. 10 constitutes a violation of Section 54.1-2915.A(3), (13) and (16) of the Code.

9. Finding of Fact No. 11 constitutes a violation of Sections 54.1-2915.A(3), (13), (16), (17) and (18), 54.1-3303.A and 54.1-3408.A of the Code, and 18VAC85-20-26.C of the Regulations.

ORDER

WHEREFORE, based on the foregoing Findings of Fact and Conclusions of Law, it is hereby ORDERED that the license of John Henry Hagmann, M.D., be REVOKED.

Pursuant to Section 54.1-2920 of the Code, upon entry of this Order, Dr. Hagmann shall forthwith give notice, by certified mail, of the revocation of his license to practice medicine and surgery to all patients to whom he is currently providing services. A copy of this notice shall be provided to the Board when sent to patients. Dr. Hagmann shall cooperate with other practitioners to ensure continuation of treatment in conformity with the wishes of the patient. Dr. Hagmann shall also notify any hospitals or other facilities where he is currently granted privileges, and any health insurance companies, health insurance administrators or health maintenance organization currently reimbursing him for any of the healing arts.

Should Dr. Hagmann seek to re-apply for a license to practice medicine and surgery, he shall be noticed to appear before the Board, in accordance with the Administrative Process Act. As an applicant, Dr. Hagman will have the burden of proving his competency and fitness to practice medicine and surgery in the Commonwealth of Virginia in a safe and competent manner.

As provided by Rule 2A:2 of the Supreme Court of Virginia, Dr. Hagmann has thirty (30) days from the date of service (the date he actually received this decision or the date it was mailed to him, whichever occurred first) within which to appeal this decision by filing a Notice of Appeal with

William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233. In the event that this decision is served by mail, three (3) days are added to that period.

Pursuant to Sections 2.2-4023 and 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public inspection and copying upon request.

FOR THE BOARD:

FOR William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

ENTERED: 7/6/2015